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EDITORIAL

Recovery: Say what you mean and mean what you say

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“When I use a word”, Humpty Dumpty said in rather a scornful tone, “it means just what I choose it to mean – neither more nor less”. Lewis Carroll, *Alice in Wonderland*

Recovery is the new buzz word. It is at the heart of NHS Mental Health policy in England (Department of Health, 2001a) and similar government pronouncements in the USA (New Freedom Commission on Mental Health, 2003), Ireland (Dublin Mental Health Commission, 2005) and New Zealand (Mental Health Commission, 1998), adopted by all the main mental health professions and hailed by many as the most significant force for change in mental health practice since the closure of the hospital asylum. But a question troubling many health professionals is what exactly “recovery” means for mental illness. In common parlance it is the return to a normal or healthy state, free of the symptoms of illness. Yet this is not the most common outcome for mental illness. Indeed for many sufferers, these disorders are associated with profound and accumulating disabilities so how can anyone talk of recovery in this context? The answer comes through the realization that many of these disabilities are not inevitable or inherent in the illness and can be avoided or ameliorated by adaptations to the environment or a change in the way the sufferer views and copes with their condition.

This is a universal truth for many incurable medical conditions, as for example the amputee who goes on to compete in the Paralympic Games or the person with acquired blindness who has learnt to get around independently. So we come to the first necessary expansion in the meaning of “recovery” – from the narrow perspective of the absence of symptoms to a broader focus on the retention and development of function. Being able to work, to go to college, to live in ordinary housing, have an active recreational life and find friendship and romance. Of course, as in the case of the blind or the amputee, the emphasis on function begs the further question of what implications this take on “recovery” has for the individual, for services and the wider community. For the individual, it means having or developing a belief in oneself, taking control over one’s life, having choice, self-confidence, the courage to take calculated risks and to take appropriate responsibility for failures as well as successes – in a nutshell, to have power (e.g., Roberts & Wolfson, 2006). Such “personal recovery” has been defined as “a way of living a satisfying, hopeful, and contributing life

even with the limitations caused by illness” (Anthony, 1993) or as “the real life experience of persons as they accept and overcome the challenge of the disability” (Deegan, 1988, p. 11). For services, it is a matter of doing as much as possible to empower the individual. To provide the treatment, advice and support to enable him or her to live and participate in the community in the way he or she chooses (Davidson et al., 2005). The emphasis is on collaboration and choice rather than coercion, the positive reinforcement of success rather than the punishment of failure and a shared involvement with professionals in how the service is provided. From the perspective of the professional, it is, for example, the difference between viewing the service user as a person who happens to have schizophrenia or labelling him or her as “a schizophrenic” – a subtle but important shift in emphasis. From the individual service user’s point of view, it is more about how the professional relates to them than what they do by way of formal therapy – the extent to which they convey a sense of caring for, and believing in them, and in imparting hope. For society it means removing the barriers to this empowerment. In the long haul, to tackle injustice, discrimination and exclusion as well as making reasonable environmental adjustments to enable all citizens to lead a safe, dignified and fulfilling life in the community.

These ideas are not new though they are probably more widely disseminated than at any earlier time in history. In fact, long before the discovery of effective medical and psychological treatments for mental illness, it was known that better outcomes could be obtained if people were treated with respect and dignity, in settings that emphasized collaboration rather than coercion. The collaborative approach was at the heart of moral treatment 200 years ago and in the social psychiatry revolution of the 1950s both of which were to a large extent a reaction against then dominant pessimism and paternalism in mental health care. The current incarnation has origins in the anti-psychiatry and survivor movement and in the call for improved civil rights for disabled people. It has indirect expression in other current policies and practices including social inclusion, the expert patient (Department of Health, 2001b) and self management (Department of Health, 2006a). In England as elsewhere, there has been a gradual movement from rhetoric to reality through the emergence of recovery tools such as the Wellness and Recovery Action Plan (WRAP; Copeland, 1999), training for workforce skills development (Woodbridge & Fulford, 2004; Care Services Improvement Partnership, 2006) and implementation guidelines (Department of Health, 2006b). There are now ways of measuring the extent to which a service is recovery-orientated (e.g., Campbell-Orde et al., 2005) and a number of interventions and strategies to promote personal recovery. These include, for example, service users working in responsible posts in mental health services (Craig et al., 2004), the recognition that persisting symptoms are not necessarily a barrier to ordinary open employment (Crowther et al., 2001; Lehman et al., 2002), and the use of psychiatric advance directives that reduce compulsory admissions (Henderson et al., 2004).

It is clear then, that the idea however expressed, has a long pedigree and it is difficult to think that the empowerment of patients, instillation of hope, and functional adaptation to disability are not worthwhile aims for mental health services or that any mental health service provider should be allowed to do anything else. Yet some nagging concerns just don’t go away. Two trouble this author particularly. First, how to safeguard against cash-strapped health and social care systems using the language of recovery (self-management, independence, discouragement of dependency) to justify service cuts as for example, the withdrawal of day services on the grounds that they encourage dependency or making token changes to headed notepaper without the financial and cultural commitment to the service reform that is so obviously necessary. Second, how to square the need to promote individual

self-determination and risk with the requirement to run a “safe” service in which harm to self or others is minimized.

For the first concern, the best safeguard lies in the commitment of the professional to provide the most effective treatments and to measure effectiveness in terms of the impact of treatment on the goals and outcomes that matter to the individual service user. Since there will be little or no additional resource attached to recovery-orientated services, it will mean doing differently with what we have got and crucially, stopping doing those things that have no evidence base or which do not reduce distress, increase occupation and employment, friendship and leisure activity. Before cutting a day service, for example, ask with what it is to be replaced and whether the same number or more people will benefit from the change. Ask also which interventions, provided by which professional or non-professional is most effective at achieving which aspect of personal recovery and at least audit the impact of service change on service user outcomes. It is extraordinary that changes to service organization and delivery can be made with no recourse to user consultation, ethical appraisal or outcome monitoring whatsoever.

For the second, there will, of course, continue to be circumstances in which the risk assessment calls for action that overrides the principle of choice but it is not these major risks that are the main concern as there are clear legal regulations to be followed where ordinary rights of consent are over-ruled in the interest of safety to self or others. The difficult issues crop up at a more subtle level. Deegan (1993) a service user with a very clear voice on matters of recovery has made the point that people need to have the right to fail in order to learn from their own mistakes. All very well but a tough call where the failure is likely to result in harmful even if not fatal consequences. For example, for many people recovery means coming off medication. But discontinuing medication is perhaps the most common reason for relapse and each relapse may well lead to a progressively worse long-term outcome. Relapse may also have undesirable consequences for family, friends and work colleagues. A relapse of mania that is accompanied by lavish spending or grossly disinhibited behaviour may result in losses that can never be restored. A wife whose husband has brought her shame and ruin is unlikely to appreciate the argument that the relapse was part of her husband’s right to learn by failure! On the other hand, some people will remain well despite all predictions to the contrary and there is no entirely reliable way of knowing who these people will be. A recovery-orientated approach can do no better than assess the risk and ensure that as far as possible the result of this risk assessment is openly shared and discussed with all concerned. But the tensions are obvious and the challenge is real enough. As most clinicians who have been around any length of time know, it does not take much by way of a change in the risk profile of a service to draw down critical attention and it probably this experience more than any other that most effectively obstructs a change in practice or reverses the implementation of more liberal approaches to the management of mental illness.

So I do have a worry – that like Humpty Dumpty, what the speaker really meant when he encouraged “recovery” may only be truly known to the speaker and even to him in hindsight. Despite these anxieties, it is hard to conceive a better way to go. An emphasis on personal recovery achieves several things that I believe are or should be at the heart of our enterprise. First it directs the mental health services to focus its effort on outcomes that matter to patients. Second it reminds us that as in all other aspects of therapy, be this medical or not, it is the patient who needs to be in the driving seat. It is they who need to learn how to manage their condition and to make the adaptations to their life in order to achieve quality despite the burden of ill health. It is our task to coach and encourage these adaptations. This does not mean that we will stop providing treatment to reduce symptoms

or providing long-term care and support to those who need it, nor that we will take the responsibility of risk assessment and management any less seriously. Rather, it means that the way in which we do these things will change to be more hopeful, empowering and inclusive of the wishes and choices of our patients.

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